

UTAH STATE DEVELOPMENTAL CENTER REQUEST FOR OUTPATIENT DENTAL SERVICES

TO AVOID DELAY IN REQUEST, PLEASE RESPOND COMPLETELY TO ALL AREAS

SERVICE REQUEST FOR:

SERVICE REQUEST FOR:				
Name:	Date of Birth:			
Social Security #:	Telephone:			
Address:				
Is the above individual currently receiving services from Disabilities? Yes □ No □	om the Division of Services for People with			
Type of service:				
PERSON REQUESTING SERVICES IF OTHER	THAN ABOVE:			
Name:	Title:			
Address:	Telephone:			
Relationship to patient (DSPD regional staff, ICF/MR	, QMRP, other):			
When is the best time to contact you?				
Additional contact (Support Coordinator, QMRP, etc.):				
Telephone:				
Legal Guardian:				
Address:	Telephone:			
INSURANCE INFORMATION:				
Name of Insurance Company(ies):				
ID#:				
Policy Holder:				
Medicaid #:	Medicare #:			
Who will pay for services not covered by insurance?				
Billing Address:	Telephone:			

MEDICAL HI	STORY INFORMATION:	

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Primary Physician:	Telephone:			
Primary Dentist:	Telephone:			
What type of anesthesia has been used for previous dental appointments (nitrous oxide, general anesthesia, local anesthesia, etc.)?				
Is the above individual currently in dental pain? Yes	S □ No □			
Please list chief dental complaint:				
When was your last dental visit (include date, provide	er and provider phone number):			
LIST PRIVATE PROVIDERS PREVIOUSLY CO	ONTACTED FOR REQUESTED SERVICES:			
Name, Address and Telephone	Reason for Denied Services			
*AUTHORIZED SIGNATURES REQUIRED PR	IOR TO SERVICE DELIVERY *			
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*1) Region Director:				
OR				
Nursing Home Administrator:				
*2) Developmental Center Medical Services Directo	r:			
*3) Developmental Center Administrator:				
*4) Developmental Center Dentist:				
5) Business Office:				

MEDICAL HISTORY FORM

MEDICAL AND DENTAL RECORDS MUST ACCOMPANY THIS FORM

For your safety please answer all questions carefully and honestly

1. Have you ever been a patient at USDC? 2. Are you taking or have you ever taken blood thinners, Coumadin, prednisone, heart pills, steroids, nerve pills, blood pressure pills. Fen Phen (diet pills) or Insulin? (circle which) 3. Do you use herbal or food supplements? if yes, please list 4. List any medications you are now taking or have taken in the past four months (Females – Are you taking a birth control pill? There is a higher incidence of "Dry Socket" with that medication. Also, if antibiotics are prescribed, the effectiveness of a birth control pill may be reduced and a pregnancy may occur): 5. Are you alliergic to, or have had an unfavorable reaction to any medication? 6. Do you litch, wheeze or get a reash from latex or a rubber product? 7. Have you had an unfavorable reaction local (numbing) or general (asleep) anesthetics? 8. Do you use recreational drugs – i.e.: L.S.D., "Speed", "Downers", Mescaline, Cocaine, others? 9. Have you ever been hospitalized or operated on? List year and reason: 10. Have you had an unfavorable reaction from previous dental treatment? 11. Do you get infections, sores, boils, sore throat or respiratory problems easily? 12. Have you or any family member had problems breathing following an anesthetic? 14. Have you had recent weight changes or history of fever or chills and excessive sweating? 15. What is your current Height? 16. Do you get frequent headaches? 17. Do you wery glasses, contact lenses, see double, or have glaucoma? (circle which) 18. Do you have/had hearing difficulties, ringing in your ears, dizziness, earaches, drainage from ears, simulati, frequent nose bleeds, difficulty breating through your nose? (circle which) 19. Do you have/had hearing difficulties, ringing in your ears, dizziness, earaches, drainage from ears, simulati, frequent nose bleeds, difficulty breating through your nose? (circle which) 19. Do you have/had betterping problems such as asthma, wheezing, T.B., chronic cough, coughing speals, excessive sweating, employema? (circle which) 19. Do yo		Yes	No
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Patient Parent Guardian (circle)	Signature		
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